**RELEASE OF INFORMATION FOR PROCESSIONG BENEFITS**

I hereby authorize Laura Kezdi-Hamzeloo, LCPC, to release any of the following requested information for the purpose of obtaining reimbursement/payment for treatment services provided directly to me or my dependents. Information may include:

1. Admitting diagnosis 4. Final diagnosis
2. Health screening 5. Designated clinical records, e.g., treatment plans,
3. Discharge summary progress notes, laboratory results, etc.

Information may be released to any or all of the following as needed:

1. Any third-party payor having 2. Review agents/auditors

responsibility for payment 3. Managed care/utilization review agents

of charges for treatment

This consent is valid until such time that all claims have been settled to the satisfaction of Laura Kezdi-Hamzeloo, LCPC or up to one year from the date of discharge from services by Laura Kezdi-Hamzeloo, LCPC, whichever is longer.

I understand that in some cases I and/or my dependents may be receiving services for which I am not insured or for which there is more than one insured (e.g., my spouse) and to share information necessary to obtain reimbursement for services.

I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate this consent any time before the expiration date so long as I submit my revocation in writing to the address listed below. Finally, the agency reviewing the clinical information and/or records will be advised not to redisclose my records to any other agency/person without my written informed consent.

I understand that I am ultimately responsible for any and all charges not paid for by my medical insurance, and that if I refuse to sign this Release of Information, I will likely have to pay for any and all charges incurred.

I certify that I am the client and that I have received a copy of this form. If I am not the client, I certify that I am duly authorized as the client’s general agent to execute the above and accept its terms.

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(print)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(client or authorized representative)

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the client did not sign this form, what is the relationship of the signer to the client? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the client did not sign, please state the reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ASSIGNMENT OF BENEFITS: In consideration of services to be provided to me or to my dependent, I hereby assign, transfer, and set over to Laura Kezdi-Hamzeloo, LCPC, all of my rights, title, and interest to reimbursement

benefits under my insurance policy(s), including any and all major medical benefits. I understand I am financially responsible to Laura Kezdi-Hamzeloo, LCPC for charges not covered by this assignment.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(person insured)